RECORDS RELEASE AUTHORIZATION

To ____

DOCTOR OR HOSPITAL

____

ADDRESS

____

____

I hereby authorize and request you to release to:

GREENVILLE PLASTIC SURGERY, P.A.

- ❑ Richard P. Rizzuti, M.D.
- ❑ J. Lynne Garrison, M.D.

400 Spring Forest Road
Greenville, NC 27834
(252) 758-6627
Fax (252) 830-5138

The complete history records in your possession, concerning my illness and/or treatment during the period from ______________________ to ______________________

Name ____

Address ____

Date of Birth ______________________ Social Security #: ______________________

Signature ______________________________ Date ______________________

(IF RELATIVE, STATE RELATIONSHIP)

____

Witness ______________________________ Date ______________________